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CLERK U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT TACOMA
BY DEPUTY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

**************, QUI TAM PLAINTIFF for and on behalf of the United States of America,

Plaintiff,

vs.

*********************,

Defendants.

CASE NO. CV13-01312 RAJ

FIRST AMENDED COMPLAINT FOR FALSE CLAIMS PURSUANT TO 31 U.S.C. § 3729 AND 31 U.S.C. § 3730

IN CAMERA AND UNDER SEAL

☒ Clerk's Action Required to Seal File

13-CV-01312-APPO

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CLERK U.S. DISTRICT COURT
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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

MARGARET COOK, QUI TAM PLAINTIFF for and on behalf of the United States of America, Plaintiff, vs. PROVIDENCE HEALTH & SERVICES, a Washington corporation; PROVIDENCE HEALTH & SERVICES - WESTERN WASHINGTON, a Washington corporation; PROVIDENCE HEALTH & SERVICES - WASHINGTON; a Washington corporation; PROVIDENCE HEALTH & SERVICES - OREGON, an Oregon corporation; PROVIDENCE HEALTH & SERVICES - MONTANA, a Montana corporation; PROVIDENCE PHYSICIAN SERVICES CO., a Washington corporation; and HEALTH SERVICES ASSET MANAGEMENT, LLC, a Washington corporation. Defendants.	**CASE NO. CV13-01312** **FIRST AMENDED COMPLAINT FOR FALSE CLAIMS PURSUANT TO 31 U.S.C. § 3729 AND 31 U.S.C. § 3730** **IN CAMERA AND UNDER SEAL** ☒ Clerk's Action Required to Seal File

COMPLAINT

COMES NOW, Qui Tam Plaintiff, Margaret Cook, by and through her attorney of record, Douglas R. Cloud, complains and alleges a cause of action as follows:

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NATURE OF THE CASE

I.

Qui Tam Plaintiff (Margaret Cook) brings this lawsuit on behalf of the United States of America pursuant to 31 U.S.C.A. § 3729 and Section 3730 et seq.

II.

A copy of the original complaint and written disclosure of substantially all material written evidence and information the plaintiff possesses has been served on the United States Government pursuant to 31 U.S.C. § 3730(b)(2) and Rule 4(i) of the Federal Rules of Civil Procedure. A copy of this First Amended Complaint will be served concomitantly on the United States Government pursuant to 31 U.S.C. § 3730(b)(2) and Rule 4(i) of the Federal Rules of Civil Procedure. This complaint is filed in camera, under seal, and may not be served upon the defendants until further order of this Court.

PARTIES, JURISDICTION AND VENUE

III.

That the defendants, Providence Health & Services, Providence Health & Services - Western Washington, Providence Health & Services - Washington, Providence Health & Services - Oregon, Providence Health System - Southern California and Providence Health & Services - Montana (hereinafter "Providence") are corporations duly organized and licensed to do business in the State of Washington. The defendants also maintain hospitals and health care facilities in the States of Oregon, Alaska, California and Montana, in addition to Washington State. To the extent these other entities are not named herein, Relator reserves the right to name these entities by later amendment of this Complaint. Specifically, Relator reserves the right to amend the complaint to include Providence Health System - Southern California as a defendant because Relator is the original source of information conveyed to the United States' Government about possible fraud against the United States committed by Providence affiliated entities operating in California. This Court has jurisdiction over the subject matter and of the parties. The acts alleged herein occurred in the

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Western District of Washington and other judicial districts in Oregon, Alaska, California and Montana within the Jurisdiction of this Court.

IV.

That the defendant, Health Services Asset Management, LLC, is a corporation duly organized and licensed to do business in the State of Washington with its primary location in the City of Renton, County of King.

V.

This court has jurisdiction under 31 U.S.C. § 3732, which provides that any action under Section 3730 may be brought in any judicial district in which the Defendants or in the case of multiple defendants, in a district where any one defendant can be found, resides, transacts business or in which any act prescribed by Section 3729 occurred. As alleged before, the acts complained of herein occurred within the jurisdiction of this Court, the Western District of Washington, as well as other districts throughout Washington, Oregon, Alaska, California and Montana.

VI.

That the defendant, Providence, does business under numerous affiliated business entities. These include Providence Health and Services, Providence Health & Services - Western Washington, Providence Health & Services - Washington, Providence Health & Services - Oregon, Providence Health System - Southern California and Providence Health & Services - Montana.

DEMAND FOR TRIAL BY JURY IS MADE

VII.

That the plaintiff hereby demands a trial by jury of all issues alleged herein that are triable by jury.

GENERAL ALLEGATIONS

VIII.

In order to acquire Medicare funds, the defendants and affiliated entities engaged in fraudulent activity by submitting statements in support of claims which it knew were false to the

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Center for Medicare Services and Washington State Department of Social and Health Services and other state agencies or agents in Washington, Oregon, Alaska, California and Montana as a condition for receiving Medicare and Medicaid funds. Specifically, defendants, individually or through its agents, submitted statements which it knew to be false in 2010, 2011, 2012 and 2013, inclusive.

IX.

That the defendants, as a condition of their participation as a provider in the Medicare and Medicaid system, agreed not to charge Medicare and Medicaid beneficiaries for any service for which Medicare and Medicaid beneficiaries are entitled to have payment made on their behalf by the Untied States Government Medicare System and/or by a State utilizing funds received from the United States Government for Medicaid Services. It is believed that the practice of submitting statements in support of claims the defendants knew were false predates plaintiff's period of employment at Health Services Asset Management, LLC which commenced in 2011.

X.

That the defendants, as a condition of payment for charges submitted by them to the United States Government for Medicare services and to the various states for Medicaid services, must submit a statement themselves or through their agents that the defendants certify their compliance with all applicable Federal and State statutes, rules or regulations relating to the submitted claim(s). Thus, the defendants knowingly used, or caused to be made or used, false records or false statements to get false or fraudulent claims allowed or paid contrary to 31 U.S.C. § 3729(a)(2).

XI.

That the defendants have repeatedly illegally received payments from the Medicare and Medicaid programs as a result of improperly billing beneficiaries for costs that are impermissible. This results in double or excessive billing of Medicare patients. Medicaid patients are forced to pay charges which cannot be validly charged by defendants to beneficiaries as Medicaid patients are not to be billed by providers for Medicaid eligible services.

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XII.

That defendants routinely double bill or over bill Medicare beneficiaries for services the beneficiaries receive. It is estimated by relator that billing errors resulting in double billings or overcharges to Medicare and Medicaid beneficiaries exceed thirty (30%) percent of claims submitted by defendants to the United States Government or the various state governments.

XIII.

That defendants routinely charge Medicare beneficiaries for care for which they are eligible for payment by Medicare resulting in a double payment by Medicare and the patient. This is contrary to the defendants' Medicare and Medicaid provider agreements with the federal and state governments and the certification made by defendants that they have followed applicable state and federal statutes, regulations and rules. Additionally, defendants routinely do not properly credit patient accounts for payments received from the United States Government and/or the patient's themselves. For those accounts where Medicare is not properly credited to patient accounts, double payment is sought by defendants and collected from patients in excess of the patient's required copays or deductibles. This results in a "double billing" for services received with both Medicare and the patient being billed for the same services.

XIV.

That the failure of defendants to properly credit patient accounts with patient's own payments and/or Medicare payments results in copays and deductible overpayments by Medicare beneficiaries, as well as the double payments described in the preceding paragraphs.

XV.

That Medicaid beneficiaries are routinely charged for care for which they are eligible for Medicaid reimbursement through the various state administered Medicaid programs in the states that defendants conduct business. This results in a double billing of the Medicaid system and the patient. Billing an eligible beneficiary for Medicaid services is violative of state and federal statutes, regulations and rules.

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WHEREFORE, plaintiff requests that this Court enter a judgment in his favor, and against the defendants for an amount consistent with the evidence, together with the cost of litigation, interest and reasonable attorney fees in accordance with 31 U.S.C. § 3730.

REQUEST FOR RELIEF ON ALL COUNTS.

WHEREFORE, plaintiff requests that this Court enter a judgment in her favor, and against the defendants as follows:

1. For compensatory damages in an amount consistent with the evidence, according to proof;

2. For interest on such damages awarded at the legal rate from the date of judgment until paid;

3. For the cost of this litigation, and reasonable attorney fees pursuant to federal and state law set forth above;

4. For such other and further relief as the Court deems just and proper; and

5. For trial of the claims alleged herein by jury.

DATED this 31st day of July, 2013.

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